is government-owned, non-profit private or proprietary. Where a hospital is part of a medical school or affiliated with such a school, it serves the dual purpose of supplying these special services and providing teaching facilities for undergraduate or graduate medical students. This set-up is ingrained in our medical teaching programs and is thoroughly understood by all.

In recent years the federal hospitals operated by the Army, Navy, Air Force and Veterans' Administration have enlarged this concept and put themselves in the position of being essential teaching units, purportedly as a means of improving the training of their own medical officers. It is easily understandable that military officials are sincerely interested in securing more extensive training for their staff physicians. But such training can be secured through the numerous private hospitals all over the country which today have a shortage of residents in all branches of medicine. With surplus residencies in private institutions, why should government add to the total of available residencies by setting up training programs of its own? In so doing, government adds to the vicious cycle of assuming the care of more patients, securing physicians to provide the care, building more beds to handle the patients, using the patients as teaching material and drafting more physicians as clinicians and teachers.

All in all, the changes in Medicare would seem to destroy a great deal that was good in the plan and at the same time, whether fortuitously or by craft, extend the areas in which government medicine can infringe on private practice.

Relative Values—A Restudy

THIS MONTH the members of the California Medical Association will be asked to participate in a restudy of the Relative Value Study with which all are familiar. Each member will be sent a work sheet and be asked to indicate on it the fees he normally charges for procedures used in his practice.

This study will bring up to date the original Relative Value Study and eliminate any inequities which might be found from the first inquiry of 1954.

California's Relative Value Study started out as an internal inquiry on the feasibility of expressing professional fees in terms of units, the units reflecting the relative worth of one procedure as against another. By the time the study was completed it became evident that such a study would have a wide range of usefulness and this has been borne out by experience. Not only their professional colleagues but many other persons and organizations who deal with medical fees are greatly in debt to the C.M.A. Committee on Fees for carrying out this outstandingly successful project.

Many physicians have established fees in their own offices on the basis of the values shown by the original study. Insurance companies have used it as a base for calculating indemnity tables. The Medicare program grasped the opportunity to use the California study as a pattern for negotiating fees with state medical association representatives. Simultaneously, the study has been most productive in establishing a nationally accepted nomenclature and a coding system for the hundreds of procedures encompassed.

The restudy at this time will reevaluate the 1956 production. It will also give physicians an opportunity to add new procedures to the lexicon or discard outmoded ones.

Copies of the work sheet will be sent direct from the California Medical Association office or through the offices of county societies which wish to handle their own distribution and add their own suggestions. Replies will come to the California Medical Association, where IBM equipment will be available for tabulating the hundreds of thousands of items included in the entire study.

Members are asked to read the general instructions printed on the inside front cover of the work sheet. They are especially requested to note on the front cover of the sheet the county in which they practice and the field of practice they follow. On the inside pages they are to list their own ideas as to the fee applicable to those procedures which they regularly perform. By concentrating on such usual items, urologists, say, will not be expressing their ideas on the fees an ENT specialist should receive, and vice versa.

Deadline for receiving completed work sheets has been set for October 31. Following that date the mechanical tabulating will be done. By handling much of the first mailing through county societies, it will be possible to provide the counties with the tabulated returns from their own areas.

Officers of the California Medical Association are hopeful that the members of the association will cooperate in this survey as they did in the first study. In so doing they will directly serve themselves and their medical association and will smooth relations and negotiations with all the public and private agencies with which organized medicine has dealings that involve fees.